

Stockport NHS Foundation Trust

Shire Hill Intermediate Care Unit

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this unannounced inspection of Shire Hill Intermediate Care Unit in response to concerns that were raised with us. Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

The Care Quality Commission undertook this focussed inspection in response to concerns that were reported to us about staffing levels, particularly at night time. We inspected the unit during the evening of 22nd September 2015. We visited the following areas:

- Ludworth Unit
- Charlesworth Unit

Our key findings were as follows:

We found that patients at Shire Hill Intermediate Care Unit were not receiving timely and appropriate care at all times. Nurse staffing levels at times were not sufficient on both units to ensure patients were cared for appropriately. There were periods of understaffing that senior managers did not address adequately or quickly and the risks associated with these periods of understaffing were not fully recognised or managed. The issues relating to understaffing had a negative impact on patient care and experience.

We found that staff completed appropriate risk assessments for patients in some cases. There was an early warning score system used on both units to identify patients who were at risk of deterioration. However, staff had not applied this system correctly in some cases and this had led to some patients not receiving timely review by a doctor or closer observation.

Staff completed records in legible and clear handwriting. However, patient records were not stored securely and some records lacked important information and contained some discrepancies.

Medicines were managed safely on both units and staff made appropriate checks when administering medication. Some patients experienced a delay in receiving their medication including pain relief and the section regarding the recording of allergies was not completed in some records.

The facilities were visibly clean, free from clutter and fit for purpose. On both units, we found some issues of concern with the standard of checks made on equipment. The unit displayed safety calendars, which gave information on pressure ulcers and falls. This information was displayed on the wall at the entrance to each unit and in the staff office on each unit. Incident reporting systems were adequate and staff were able to use the incident reporting system effectively.

Infection control processes and procedures were in place, which helped safeguard patients from avoidable infections.

Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.

Importantly, the trust must:

- Ensure that safe staffing levels are provided on both units at all times.
- Ensure that staff undertake and record patient observations consistently and accurately.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Shire Hill Intermediate Care Unit

Detailed findings

Services we looked at

Medical care

Detailed findings

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Background to Shire Hill Intermediate Care Unit

Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

Rehabilitation services are provided by a team of nurses, general practitioners and therapists. Occupational therapy and physiotherapy are available on the inpatient units.

Stockport NHS Foundation Trust have overall responsibility for the running of services at Shire Hill Intermediate Care Unit.

Our inspection team

The team that inspected this service included two CQC inspection managers and two CQC inspectors.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about Shire Hill Intermediate Care Unit and Stockport NHS Foundation Trust.

As part of the inspection we carried out an unannounced visit on 22nd September 2015 between 9.30pm and 11.30pm to:

Shire Hill Intermediate Care Unit

We looked at a range of policies, procedures and other documents relating to the running of the service.

We spoke to five staff members, 12 patients and reviewed 16 patient records.

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Information about the service

Shire Hill Intermediate Care Unit is a 36 bedded unit situated in Glossop and offers inpatient rehabilitation services to patients over the age of 18 in the Tameside and Glossop areas. Care is delivered over two inpatient units; the Ludworth and Charlesworth units. These units are situated in the same building on two separate floors.

Rehabilitation services are provided by a team of nurses, general practitioners and therapists. Occupational therapy and physiotherapy are available on the inpatient units.

Stockport NHS Foundation Trust have overall responsibility for the running of services at Shire Hill Intermediate Care Unit

Summary of findings

The inspection team found that patients at Shire Hill Intermediate Care Unit were not receiving timely and appropriate care at all times. Nurse staffing levels at times were not sufficient on both units to ensure patients were cared for appropriately. There were periods of understaffing that senior managers did not address adequately or quickly and the risks associated with these periods of understaffing were not fully recognised or managed. This understaffing had a negative impact on patient care and experience.

We found that staff completed appropriate risk assessments for patients in some cases. There was an early warning score system used on both units to identify patients who were at risk of deterioration. However, staff had not applied this system correctly in some cases and this had led to some patients not receiving a timely review by a doctor or closer observation.

Staff completed records in legible and clear handwriting. However, we found that patient records were not stored securely and some records lacked important information and contained some discrepancies.

Medicines were managed safely on both units and staff made appropriate checks when administering medication. We found that some patients experienced a delay in receiving their medication including pain relief and the section regarding the recording of allergies was not completed in some records.

The facilities were visibly clean, free from clutter and fit for purpose. On both units, we found some issues of concern with the standard of checks made on equipment. The unit displayed safety calendars, which gave information on pressure ulcers and falls. This information was displayed on the wall at the entrance to each unit and in the staff office on each unit. Incident reporting systems were adequate and staff were able to use the incident reporting system effectively.

Infection control processes and procedures were in place, which helped safeguard patients from avoidable infections.

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Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.

Are medical care services safe?

Incidents

- Incident reporting systems were adequate and staff were able to use the incident reporting system effectively.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free care'. Monthly data is collected on pressure ulcers, urinary tract infections (for people with catheters), blood clots (venous thromboembolism or VTE) and falls.
- The unit displayed safety calendars, which gave information on pressure ulcers and falls. This information was displayed on the wall at the entrance to each unit and in the staff office on each unit.
- The information displayed on the Charlesworth Unit showed that there were four incidents of patient falls in the month of August and four incidents of patient falls from 1st September to 22nd September.
- The information displayed on the Ludworth Unit showed that there were 12 incidents of patient falls in the month of August which is higher than we would expect and four incidents of patient falls from 1st to 22nd September which is slightly higher than we would expect. We were unable to establish whether these falls were preventable as the records listing the falls did not contain sufficient information to identify individual patient records.

Cleanliness, infection control and hygiene

- Infection control processes and procedures were in place that helped safeguard patients from avoidable infections.
- Staff followed infection control and prevention guidelines during patient contacts, including washing their hands and changing their personal protective equipment.
- Staff cared for patients with infections in appropriate isolation rooms. These rooms had clear signage to indicate that additional infection control measures were to be used on entering and leaving the rooms.

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- Waste was segregated appropriately and was placed in clearly labelled bags for appropriate disposal.

Environment and equipment

- The facilities were visibly clean, free from clutter and fit for purpose. On both units we found some issues of concern with the standard of checks made on equipment.
- There were emergency resuscitation trolleys on both Charlesworth and Ludworth units.
- There was a checklist for staff to complete on a daily basis to check all the parts of the emergency resuscitation trolleys. This checklist included sections to check that all the equipment in the trolley was in date and in good working order.
- We reviewed four weeks of checklists on the Ludworth unit and checks were undertaken daily, apart from on one occasion when there was no check undertaken on the emergency resuscitation trolley.
- We checked all pieces of equipment contained in the emergency resuscitation trolleys on both units.
- On the Ludworth unit, all equipment contained in the emergency resuscitation trolley was found to be in date and in good working order.
- On the Charlesworth unit, we found two pieces of equipment which were out of date. These were an oxygen mask and medical tubing, the expiry dates were August 2015 and February 2012 respectively. A staff member had signed the checklist for this trolley on 21st September 2015 and this implied that expiry dates of equipment had been checked. If equipment is used after its expiry date, there is the possibility that the equipment would not work as effectively as it should.

Medicines

- Medicines were managed safely on both units and staff made appropriate checks when administering medication. However some patients experienced a delay in receiving their medication and there was missing information in relation to patient allergies in some records.

- We observed staff undertaking the night time medication round. Staff undertook appropriate checks when administering medication including checking the patient's name, date of birth and allergy status.
- Staff told us that this medication round took a long time to complete each night as the units were large and there was only one registered nurse on shift for each unit most nights.
- This medication round took approximately two hours to complete during our visit.
- We observed some patients who were woken up from sleep to have their medication administered.
- We reviewed eight medication charts and the date on one of these charts was incorrect. The date that medication had been administered was stated as the 21st September but staff had administered the medications on 22nd September. The patient could have received their medications twice if this error had not been noticed. Staff were informed of this and amended the chart accordingly.
- In two of the charts we reviewed, the allergy section was not completed.

Quality of records

- We reviewed 16 patient records.
- Staff completed records in legible and clear handwriting. Patient records were easily located and we found that information about plans of care was easily located. However we found that patient records were not stored securely and some records lacked important information and contained some discrepancies. Patient records were stored in the staff office on each unit in trollies; these offices were easily accessible from the main corridor area and the door to the office was not locked.
- In all the records reviewed, staff had written entries in clear and legible handwriting.
- In one of the eight medication charts, a date error was noted. This was reported to ward staff and amended accordingly.
- In one of the 16 records reviewed, staff had not completed admission documents fully. Staff had not completed the cognition and communication area of

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the admission document. In this case, it was identified that the patient had difficulties with communication and staff would have needed to be aware of these difficulties.

- We reviewed nine charts which recorded how often patients were checked and repositioned by staff, offered fluids and the opportunity to use the toilet. We reviewed these charts between 9.35pm and 9.50pm. In three of these cases, staff had completed the charts to indicate they had undertaken checks on patients with a recorded time of 10pm. This meant that the charts had been completed in advance of the time recorded on the chart.
- We reviewed 16 observation charts, which are used to record patients vital signs. In five of these charts, there were entries which did not indicate the time staff had taken the vital signs. This could have resulted in patients not receiving observations within an appropriate timescale.

Assessing and responding to patient risk

- We found that staff completed appropriate risk assessments for patients in relation to pressure ulcers and falls in most cases. Staff shared information at handover times about patients who were at particular risk of suffering falls and pressure ulcers. There was an early warning score system used on both units to identify patients who were at risk of deterioration. An early warning score system is used to identify patients who are at risk of deterioration and it prompts staff to take appropriate action in response to any deterioration. Staff had not applied this system correctly in some cases and this had led to some patients not receiving a timely review by a doctor, or closer observation; despite the early warning score indicating the need for this.
- In four of the 16 records we reviewed, staff had completed appropriate falls risk assessments and reviewed these on a weekly basis.
- In all 16 records, there was evidence that staff had fully completed appropriate pressure ulcer risk assessments and staff had updated these assessments regularly where appropriate.
- A patient information board was displayed in the unit staff office and this board included information relating to patients who were at risk of falls.
- A printed handover sheet was provided to all staff on duty. This sheet identified which patients on the unit were at risk of falls and pressure ulcers.
- In one of the 16 records reviewed, staff had not fully completed the falls risk assessment at the time of admission. Staff had not recorded information relating to the patient's previous history of falls, which meant that staff had recorded a lower risk score for the patient than should have been. The patient subsequently suffered a fall following admission to the unit and did not suffer any significant injury. Staff reviewed the falls risk assessment a week following this fall and did not record the fall in this assessment, which meant they recorded a lower risk score again. The falls risk assessment guidance indicated that staff should have reviewed this assessment weekly. In this case, staff had not completed the falls risk assessment for 16 days. This could have led to a delay in identifying a change in the patient's risk of falls.
- There was an early warning scoring system in use on both units. This scoring system included clear and easy to follow guidance for each score value. This scoring system and guidance sheet was printed and attached to each patient's record.
- Seven of the 16 observation charts reviewed showed that patients had experienced a delay in staff taking their observations, as indicated by the early warning score guidance for the unit. In three of these cases, the delay was 21 hours. These delays could have led to a delay in patients receiving a timely review and treatment from a doctor.
- Six of the 16 observation charts reviewed showed staff had recorded incorrect scores and totals of the early warning score. This resulted in staff recording a lower score than should have been recorded. In two of these cases there had been a further deterioration in the patient's observations and early warning score. This was highlighted to staff immediately and a medical review for these patients was requested.
- The early warning score guidance for all patients stated that they should have a minimum of once daily observations if their condition was stable. In three of the

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records we reviewed, staff had not taken observations for patients on one, two and four days respectively. In two of these cases the patient's early warning scores had increased when staff took subsequent observations. This meant that the patient's condition had deteriorated in the intervening time.

Nurse staffing

- We found that nurse staffing was not adequate at times on both units to ensure patients were cared for. There were periods of understaffing which senior managers did not address adequately or quickly. The risks associated with these periods of understaffing were not fully recognised or managed. We observed that these periods of understaffing had a negative impact on routine duties of nursing staff, patient care and patient experience.
- During our visit, there were three registered nurses and four health care support workers on duty to care for 36 patients over two units; this gave a nurse to patient ratio of one registered nurse to care for 12 patients. These staff included one registered nurse and one health care support worker from a nursing agency, both of whom had received an appropriate induction to the ward area. One registered nurse had swapped her shift from another day to cover the night shift. The unit is not required to meet the national guidelines as it is a community service. However the unit must still provide a safe level of registered nursing staff to care for patients.
- Staff told us that they were very often short staffed and found it difficult to carry out all their duties on the staffing ratios provided at night time. In particular, they told us they found it difficult to undertake routine tasks such as checks of controlled drugs and equipment checks. They also advised that at times they were unable to take a break during a twelve hour shift, as it would leave the units with no registered nursing staff.
- Staff told us that on some occasions there was only one registered nurse on duty for both units, leaving a nurse to patient ratio of one nurse to 36 patients. This was supported when we reviewed the duty rota for staffing on the units. This showed that on three occasions in a two week period, there was only one registered nurse planned to be on duty for a night shift. This meant that there would have only been one registered nurse to care for 36 patients over two units, on different floors. However the trust has provided additional assurance and evidence that on those occasions additional temporary staff were on duty to ensure that at least two registered nurses were on duty for all night shifts.
- We reviewed checklists of the emergency resuscitation trolley, and we found that on one occasion in four weeks staff had not checked the trolley. According to staffing figures provided by the trust on the date of this missed check, the unit was short staffed by one registered nurse.
- We reviewed checklists for weekly and daily cleaning tasks. We reviewed the checklist records from 36 consecutive days. On 13 days, staff had not undertaken the checks or had not completed the checklist fully. On five of these occasions, staff had stated the reason for not completing the checks as lack of staff. The staffing figures provided by the trust for these dates showed that on two of the dates the unit was short staffed by one registered nurse, on one of the dates the unit was short staffed by one health care support worker and on one date, the unit was short staffed by two registered nurses.
- Staff told us that the night time medication round took a long time to complete each night as the units were large and there is only one registered nurse on shift for each unit most nights. This results in one nurse caring for 18 patients.
- Patients told us that they sometimes received their medications late at night and later than they would like.
- We observed the medication round during our visit and this took one staff member approximately two hours to complete for one unit. We observed staff waking patients from sleep to receive their medication.
- We observed that the nurse undertaking the medication round was interrupted a number of times during this round and called to other areas of the unit.
- Staff told us that other staff on opposing units often call on them to leave their unit to check controlled drugs and other medications. The units are comprised

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of long corridors of single rooms, one unit being upstairs and the other unit downstairs. This would mean that a unit could be left without any registered nursing staff for a period of time during a night shift.

- We observed a 25 minute period where there were no registered nurses on one of the units. During 15 minutes of this period, there were no registered nurses or health care support workers present on one of the units. During this period, a patient who required assistance and supervision to walk was observed mobilising unsupervised and began to stumble. The inspection team had to observe the patient until the nursing staff returned.
- Patients told us that the staff at the unit are kind, compassionate and helpful but always busy, especially at night time. Patients told us that they sometimes have to wait longer than they would like to receive assistance at night time.
- The staffing figures from the trust showed that in September 2015 there were 28 night shifts, which were short staffed by at least one registered nurse.

Medical staffing

- Medical staffing on the unit was adequate to ensure patients received timely and safe care. Staff were able to access medical advice when they needed to.
- Local general practitioners provided medical cover for patients on the units during the week from 9am to 6pm.
- Nursing staff had access to medical staff at Stepping Hill Hospital for advice on patient treatment and care including out of hours.
- Staff confirmed that medical advice was easily accessible.
- There was evidence in all records of regular medical reviews for patients.

Are medical care services effective?

Pain relief

- We found that staff were administering controlled drugs including pain relief at the end of their medication round. Staff told us that this was because they required a second person to check controlled drugs and due to short staffing; this could not be done before all the other medications had been administered. This led to a delay in patients receiving pain relief.
- We observed staff leaving the administration of controlled drugs until the end of their medication round.
- We also reviewed the controlled drugs record book. Records in this book indicated that controlled drugs were often given late at night.

Are medical care services caring?

Compassionate care

- We observed staff interacting with patients.
- Staff treated patients with dignity and respect during all interactions we observed.
- We observed four patients did not have their call bells to hand. These patients required supervision when mobilising. This meant that they could not call staff for assistance.

Are medical care services responsive?

Meeting peoples individual needs

- We observed call bells which were answered promptly on three occasions. On two occasions we observed call bells ringing between four and six minutes before they were answered.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The trust must ensure that safe staffing levels are provided on both units at all times.
- The trust must ensure that staff undertake and record patient observations consistently and accurately.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 18 The trust must provide sufficient numbers of suitably qualified and experienced staff to make sure that patients' needs are met.

Regulated activity	Regulation
Nursing care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12 (1)(2) (a)(b)(c)(d) Care and treatment must be provided in a safe way for service users. The trust must ensure that staff are appropriately completing early warning scores and acting appropriately on these scores.